Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Samuel Henneberry, a prisoner at HMP Whitemoor, on 10 May 2025

A report by the Prisons and Probation Ombudsman

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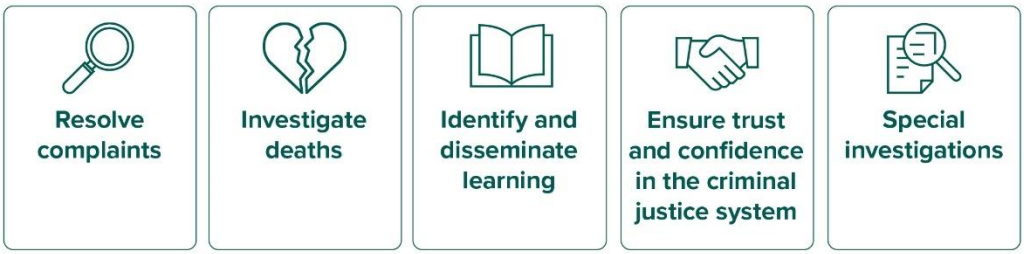
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In July 2023, Mr Samuel Henneberry was sentenced to 15 years imprisonment for manslaughter. He died of end-stage heart failure which was caused by ischaemic heart disease (when blood poorly flows to the heart and damages it) and ischaemic cardiomyopathy (when the heart muscle cannot pump blood well). He was 64 years old when he died on 10 May 2025 in HMP Whitemoor. We offer our condolences to Mr Henneberry's family and friends.

4. The Ombudsman's office wrote to Mr Henneberry's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Henneberry's clinical care at HMP Whitemoor. The clinical reviewer's report is attached as Annex 1. The clinical reviewer concluded that the clinical care Mr Henneberry received at Whitemoor was of a good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Henneberry's medical records contained evidence of excellent individualised end of life care planning. She made no recommendations.

6. The PPO investigator investigated the non-clinical issues relating to Mr Henneberry's care.

7. We did not find any non-clinical issues of concern. We make no recommendations.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Good Practice

9. We commend healthcare and prison staff efforts to involve Mr Henneberry's family in the last few months of his life by moving his son, a resident in the same prison, to the healthcare unit so that they could be closer.

Adrian Usher **December 2025**
Prisons and Probation Ombudsman

Inquest

The inquest hearing was held on 12 December 2025. The Coroner concluded that Mr Henneberry died of natural causes.

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